NORTH CAROLINA DIVISION OF MH/DD/SAS

Proposed New CAP-MR/DD Services*

(This package includes the proposed new CAP-MR/DD services in the new format.)*

1-12-04

NORTH CAROLINA DIVISION OF MH/DD/SAS

Proposed New CAP MR Services

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NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Case Management

Service Definition and Required Components:

Case Management is a service that assists individuals who receive waiver services in gaining access to needed Waiver and other State Plan services, as well as needed medical, social, educational and other services, regardless of the funding source for the services to which access is gained. Case Managers are responsible for ongoing monitoring of the provision of services included in the individual's Person Centered Plan. Case Managers shall initiate and oversee the process of assessment and reassessment of the individual's level of care and the review of Plans of Care. Additionally, Case Management, for the purpose of discharge planning, may be provided while the recipient is in a hospital if it does not duplicate discharge planning activities and is provided up to 30 days prior to the recipient's discharge from the hospital. Case Management is a required service for all CAP-MR/DD funding recipients and is assumed ordered for all recipients. **The Case Manager is required to have at least one face-to-face contact with the waiver recipient each month.** The Case Manager includes this contact in the Case Management monitoring schedule in the person's Person Centered Plan. The Case Manager is also responsible for following the other parts of the Case Management monitoring schedule. The Case Manager documents any deviation from the Case Management monitoring schedule in the case management documentation notes. Case Management activities outside of those indicated in the Case Management monitoring schedule must be reflected in the Action Plan of the Person Centered Plan.

Case Management is locating, obtaining, coordinating, and monitoring social, habilitative, and medical services as well as other services related to maintaining the person's health, safety, and well-being in the community. The Case Manager's responsibilities are discussed throughout this manual in regard to specific topics. Primarily, they include:

- Coordinating and monitoring the screening of the CAP-MR/DD funding recipient to be sure that they are eligible for CAP-MR/DD participation;
- Obtaining input from the person/providers/significant others about the service delivery process and seeking information from anyone in an effort to obtain needed services/supports on behalf of the person;
- Developing the Person Centered Plan, preparing notices for planning team meetings, facilitating person-centered planning, circle of friends, mini-planning teams, revising the Plan as needed and securing approval of the Plan; and

- Informing significant others about the person's situation and the case manager's efforts on behalf of the person with the consent of the person/legally responsible person.

- Locating and coordinating sources of help from within the family and community so that the individual receives available natural and community supports. Completing application forms to assist in receiving community and other formal service supports.
- Facilitating the service delivery process, beginning with screening, and including the identification and procurement of services, on-going monitoring of care and services, and the annual reevaluation of the individual's needs and services. This includes making sure that the individual accesses the Single Portal Process as described in the Single Portal Rules.
- Monitoring the individual's situation to assure quality care as well as the continued appropriateness of the services and CAP-MR/DD participation, including review of documentation or providers, provider claims, and evaluation/progress summaries by providers. This includes observation of service delivery. See Section 15 for guidance on this.
- Observing the person's educational services, including attending IEP Meetings and school transition meetings, and referring/linking to services.
- Coordinating with Medicaid income maintenance staff regarding the individual's Medicaid eligibility and the meeting of applicable deductibles. This includes planning with the income maintenance caseworkers, Provider Agencies, individuals, and families/primary caregivers on how deductibles will be met.

Provider Requirements:
For case management services, the provider may not provide direct services or interventions to the identified consumer.

Staffing Requirements:
Worker Qualifications: The case manager must be a Qualified Professional or Associate Professional in accordance with 10A NCAC 27G .0104.
Case managers must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation.

Service Type/Setting:
Case management service can be provided in any setting.

Program Requirements:
N/A

Utilization Management:
Lead Agencies should provide the number of Case Management hours each month that the person needs, no more or less. The frequency of Case Management provided is determined by individual needs and situations and must be provided as specified in the Person Centered Plan. The assumption is that the number of Case Management hours will vary from person to person, with some individuals requiring less and some requiring more time.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Personal Care.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Case Management is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
The Lead Agency keeps Case Management notes/logs signed by the Case Manager that provide the date of Case Management activity; the time involved in the activity; and a description of the activity. All case management service notes/log must meet the requirements list the Division Mental Health/Development Disability/Substance Abuse Service's Services Record Manual(APSM 45-2).

Service Exclusions:
CAP-MR/DD Case Management may not report Case Management billable hours at the same time of day an Area Program psychiatrist/therapist or direct enrolled Mental Health provider is billing Medicaid. Writing reports to legal bodies for the purpose of accessing services/supports on behalf of the person, including preparing guardianship, limited guardianship, health care power of attorney, and/or mental health power of attorney application forms is not billable under CAP-MR/DD Case Management. Attending the guardianship hearing is also not billable under CAP-MR/DD Case Management.
CAP-MR/DD Case Management does NOT include recruiting, training, or supervising staff. Those tasks are the responsibility of the Provider Agency.
CAP-MR/DD Case Management does not include transporting individuals, purchasing equipment and supplies, and delivering equipment and supplies. Case Management does include the coordination and arranging of transportation and the coordination and arranging of purchasing equipment and supplies for Waiver recipients. Lead Agencies may contract for Case Management Services. Agencies other than the Lead Agency may not provide Case Management and other Waiver services for the same person.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

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Personal Care Services - revised definition

Service Definition and Required Components:
Personal Care is a service that offers assistance which may include support, supervision and engaging consumer participation with eating, bathing, dressing, personal hygiene and other activities of daily living. (This service does not include active treatment, habilitation or training activities. Support and engaging consumer participation describes the flexibility of activities that may encourage the consumer to maintain skills gained during active treatment and/or habilitation while also providing supervision for independent activities of the consumer.) This service may include assistance with preparation of meals, but does not include the cost of the meals themselves. When specified in the Person Centered Plan, this service may also include such housekeeping chores as bed making, dusting and vacuuming, which are incidental to the care furnished, or which are essential to the health and welfare of the individual, rather than the individual's family.

Provider Requirements:
Personal Care services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Personal care providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:
Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10 NCAC 27G .0204; additional competencies as specified in attachment "Direct Care Staff/Competencies." Client specific competencies to be met as identified by the individual's treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation. Staff providing Level II personal care have additional training/instruction specific to the medical and/or behavioral needs of the consumer.

Family/Friend Qualifications - Must meet client specific competencies. Case manager reviews worker qualifications in relation to competencies as specified on individual's plan of care.

Supervision of personal care providers will be furnished by:

1. A registered nurse, licensed to practice nursing in the State.
2. A Qualified Professional or Associate Professional when provided by an LME/Area Authority or certified Private Provider Agency.
3. Consumers/families using consumer directed supports may direct their own services.

Frequency or intensity of supervision as indicated in the Person Centered Plan.

Service Type/Setting:

Personal care is a direct periodic service that may be provided to an individual or group of individuals. It may take place in a range of settings, such as the individual's home, ????

Program Requirements:

N/A

Utilization Management:

Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:

The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

And

Personal Care is available in two levels of intensity of service. Consumers who have overall NCSNAP scores of 1 through 4 will be considered eligible only for Level I. Consumers who have an overall NCSNAP score of 5 or who have a score of 4 in either the domains of medical or behavioral need may be considered for Personal Care Level .

Continued Stay Criteria:

The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.

B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.
E. Recipient is regressing; the service plan must be modified to identify more effective interventions.

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Personal Care.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants Personal Care.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Personal Care is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Provider must maintain a client record date of service, duration of service, task performed, signature (initials if full signature is included on the page). This is to be documented daily.

Service Exclusions:
Payment will not be made for services furnished to a minor by the child's parent (or step-parent), or to an individual by that person's spouse.

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SERVICE STANDARDS

Respite Care

Service Definition and Required Components:

Respite Care is a service that provides periodic relief for family or primary caregiver. In order to be considered the primary care giver, a person must be principally responsible for the care and supervision of the individual, and must maintain his/her primary residence at the same address as the covered individual.

Provider Requirements:

Respite must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time.

Staffing Requirements:

Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10A NCAC 27G .0204; additional competencies as specified in attachment "Direct Care Staff/Competencies." Client specific competencies to be met as identified by the individual's treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation.

Staff providing Level II respite must have additional training/instruction specific to the medical and/or behavioral needs of the consumer.

Family/Friend Qualifications - Must meet client specific competencies.

Service Type/Setting:

This service may be provided in the individual's home or in an out-of-home setting. Respite Care may not be provided in a group home setting; however may be provided in a facility-based respite home.
Respite care will be provided in the following location(s):

1. Individual's home or place of residence
2. Medicaid certified ICF/MR

3. Licensed respite care facility
4. Other community care residential facility approved by the State that its not a private residence (Specify type):Alternative Family Living

Program Requirements:
N/A

Utilization Management:
N/A

Entrance Criteria:
Respite Care is available in two levels of intensity of service. Consumers who have overall NCSNAP scores of 1 through 4 will be considered eligible only for Level I. Consumers who have an overall NCSNAP score of 5 or who have a score of 4 in either the domains of medical or behavioral need may be considered for Respite Care Level II.

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
N/A

Documentation Requirements:
The following documentation is required if Respite is the only service received:
1. Identification/face sheet and diagnostic information;
2. Special behavioral conditions, nutritional, medical, medications to be administered, or other service needs of the consumer. These special instructions shall be given to the respite provider and no specific service plan is required for respite care.
   Note: For CAP-MR/DD consumers, the plan of care shall reference Respite Services.
3. Service notes shall include:
   a. The date(s) of the service and for hourly services duration of the service event;
   b. Tasks performed including any comments on any behaviors, etc., which are considered relevant to the consumer's continuity of care; documentation that special instructions were followed, etc.; and
   c. Signature (initials if corresponding full signature included on the page)

Service Exclusions:

Respite Care may not be provided by the recipient's primary caregiver(s), parent(s), spouse, step-parent(s), foster parent(s), or person who resides in the recipient's primary place of residence.

FFP will not be claimed for the cost of room and board except when provided as part of respite care furnished in a facility approved by the State that is not a private residence.

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SERVICE STANDARDS

Adult Day Health

Service Definition and Required Components:
Adult Day Health Services is a service furnished 4 or more hours per day on a regularly scheduled basis, for one or more days per week, in an outpatient setting, encompassing both health and social services needed to ensure the optimal functioning of the individual. Meals provided as part of these services shall not constitute a "full nutritional regiment" (3 meals per day). This service is for adults who are aged, disabled, and handicapped who need a structured day program of activities and services with nursing supervision.
Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings.

Provider Requirements:
Adult day health must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult's independence, and promoting social, physical, and emotional well-being. Services must include health services and a variety of program activities designed to meet the individual needs and interests.

Staffing Requirements:
Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27 G .0204; personnel requirements in 10A NCAC 27G .0204; competencies and supervision requirements in 10A NCAC 27G .0204; additional

competencies as specified in attachment “Direct Care Staff/Competencies.” Client specific competencies to be met as identified by the individual’s treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check.

Service Type/Setting:
Services are provided in a certified Adult Day Health Care facility.

Program Requirements:
Adult Day Health must be provided in a certified Adult Day Health facility. This service is for adults who are aged, disabled, and handicapped who need a structured day program of activities and services with nursing supervision. It is an organized program of services during the day in a community group setting for the purpose of supporting an adult’s independence, and promoting social, physical, and emotional well-being. Services must include health services and a variety of program activities designed to meet the individual needs and interests.

Utilization Management:

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient’s person centered plan or the recipient’s continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient’s level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Adult day health .

2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Adult Day Health is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Attendance records of the Adult Day Health must be maintained and the person's attendance recorded. Participation in the program and care received at the Center must also be documented. Follow the guidelines provided in the Division MH/DD/SAS Service Record Manual (APS-M 45-2 September 1, 2003; a reference is contained that refers documentation requirements to the Division of Aging web site for North Carolina Adult Day Care and Day Health State Standards for Certification –10A NCAC 6S.

Service Exclusions:
This service may not be provided at the same time of day that a person receives Interpreter Service, Respite, Residential Support, In-Home Aide , Supportive Employment , Transportation, or one the regular Medicaid service that works directly with the person such as PCS, Home Health Service, or Individual Therapies. This service may not be provided on the same day as Home and Community Support. Transportation to/from the Adult Health center is not a part of this service definition.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Supported Employment Services

Service Definition and Required Components:
Supported employment services, which consist of paid employment for persons for whom competitive employment at or above the minimum wage is unlikely, and who, because of their disabilities, need intensive ongoing support to perform in a work setting.

Supported employment includes activities needed to sustain paid work by individuals receiving waiver services, including supervision and training. When supported employment services are provided at a work site in which persons without disabilities are employed, payment will be made only for the adaptations, supervision and training required by individuals receiving waiver services as a result of their disabilities, and will not include payment for the supervisory activities rendered as a normal part of the business setting.

Transportation will be provided between the individual's place of residence and the site of the habilitation services, or between habilitation sites (in cases where the individual receives habilitation services in more than one place) as a component part of habilitation services. The cost of this transportation is included in the rate paid to providers of the appropriate type of habilitation services.

Provider Requirements: Supported Employment must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina.

Staffing Requirements:
Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10A NCAC 27G .0204; additional competencies as specified in attachment “Direct Care Staff/Competencies.” Client specific competencies to be met as identified by the individual’s treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation.

Service Type/Setting:
Supported employment is conducted in a variety of settings, particularly work sites in which persons without disabilities are employed.

Program Requirements:
Generally, only one service that directly involves the person is provided at a time.

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Supported employment .
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Supported Employment is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency

Documentation Requirements:
Maintain a service note documentation signed and dated by the individual providing the service that documents the service. Service note documentation must meet the requirements outlined in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:
FFP will not be claimed for incentive payments, subsidies, or unrelated vocational training expenses such as the following:

1. Incentive payments made to an employer to encourage or subsidize the employer's participation in a supported employment program;

2. Payments that are passed through to users of supported employment programs; or

3. Payments for vocational training that is not directly related to an individual's supported employment program.

Supported employment services furnished under the waiver are not available under a program funded by either the Rehabilitation Act of 1973 or P.L. 94-142. Documentation will be maintained in the file of each individual receiving this service that:

- The service is not otherwise available under a program funded under the Rehabilitation Act of 1973, or P.L. 94-142.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Environmental Accessibility Adaptations

Service Definition and Required Components:
Environmental Accessibility Adaptations are equipment and physical adaptations to the recipient's home which are required by the needs of the recipient as documented in the Person Centered Plan, as necessary to ensure the health, safety and welfare of the recipient; enable the recipient to function with greater independence in the home; and are of direct and specific benefit due to the disability of the recipient. Environmental modifications shall exclude those adaptations or improvements to the home which are not of direct and specific benefit to the recipient due to his/her disability. Adaptations which add to the total square footage of the home are excluded from this benefit.

This service is provided only for clients living in a private residence. Exceptions to this requirement may be authorized when documented in the Person Centered Plan as meeting the following criteria:

a) the service would enable reunification of the recipient with family members; or
b) the item is portable and can be used in a number of settings
c) the modification is cost effective compared to the provision of other services that would be required in an inaccessible environment.

Environmental modifications include:

- Installation, maintenance and repairs of ramps and grab-bars;
- Widening of doorways/passageways for handicap accessibility;
- Modification of bathroom facilities including handicap toilet, shower/tub modified for physically involved persons, bedroom modifications to accommodate hospital beds and/;or wheelchairs;
- Modification of kitchen counters, home fixtures, electrical outlets, light switches, thermostats, shelves, closets, sinks, counters, cabinets and doorknobs;
- Shatterproof windows;
- Floor coverings;
- Modifications to meet egress regulations;
- Alarm systems/alert systems including auditory, vibratory, and visual to ensure the health, safety and welfare of the person *(includes signaling devices for persons with hearing and vision loss)*;
- Fences to ensure the health, safety and welfare of a waiver recipient who lives in a private home and does not receive paid supervision for 10 hours per day or more;
- Video cameras to ensure the health, safety and welfare of a waiver recipient who must be visually monitored while sleeping for medical reasons, and who

resides in a private home without paid supervision during sleep hours;
- Stair mobility devices;
- Barrier-free lift/pulleys/mobility devices;
- Stationary/built-in therapeutic table;
- Stationary ramps;
- Weather protective modifications;
- Other requirements of the applicable life safety and fire codes.

The service will reimburse the purchase, installation, maintenance and repair of environmental modifications and equipment. This service cannot be used to purchase locks. Repairs are covered when the cost is efficient compared to the cost of the replacement of the item only after coverage under warranty is explored.

Environmental modifications will only be provided as a waiver service when they are necessary to meet the needs of the recipient, prevent institutionalization and payment is not available as part of a Medicaid state plan option.

All services shall be provided in accordance with applicable State or local building codes.

Provider Requirements:
N/A

Staffing Requirements:
Must meet applicable state and local building codes

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
Environmental Accessibility adaptations are provided to ensure the health, safety and welfare of the recipient; enable the recipient to function with greater independence in the home; and are of direct and specific benefit due to the disability of the recipient.

Documentation Requirements:
The Case Manager must insure that adequate/appropriate documentation is obtained to identify the person's needs, as well as types adaptation required. Copy of the physician's signature certifying medical necessity is included with the request for Environmental Accessibility adaptations. The physician may sign a statement on the assessment/recommendation certifying that the requested adaptation is medically necessary or may sign a separate document. The Lead Agency maintains an invoice from the supplier/installer that shows the date the adaptation was provided to the person, description of the adaptation and the cost including related charges. For adaptations that require permits for construction or installation, a receipt for the permit is required if the cost is claimed.

Service Exclusions:
The total cost of all Environmental Accessibility Adaptations provided in one year cannot exceed $5,000.00

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Transportation

Service Definition and Required Components:
Service offered in order to enable individuals served on the waiver to gain access to waiver and other community services, activities and resources, specified by the Person Centered Plan. This service is offered in addition to medical transportation required under 42 CFR 431.53 and transportation services under the State plan, defined at 42 CFR 440.170(a) (if applicable), and shall not replace them. Transportation services under the waiver shall be offered in accordance with the individual's Person Centered Plan.

Additional Medicaid payment will not be provided to provider agencies to provide transportation to and/or from the person's residence and the site of a habilitation service when payment is included in the established rate paid to the provider.

Provider Requirements:
Provider must meet safety code. Provider must have insurance coverage as required by North Carolina law and driving record check.

Staffing Requirements: A valid North Carolina driver's license is required to provided this service.

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:
N/A

Entrance Criteria:
N/A

Continued Stay Criteria:
N/A

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Transportation.

2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
N/A

Documentation Requirements:
The Local lead Agency bills transportation services.

1. If the trip is being billed by the mile rather than by an established charge, a record shall be maintain that documents the date the service is provided, the specific activity that the person is being transported to/from, and the mileage related to transporting the person. The person providing the transportation shall sign this record.
2. If the trip is being billed with an established charge per trip, the signature of a representative providing the transportation is required.

Service Exclusions:
Whenever possible, family, neighbors, friends, or community agencies which can provide this service without charge will be utilized. Transportation from a child's home to school or from the school to the child's home is the responsibility of the public school system.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Specialized Medical Equipment and Supplies

Service Definition and Required Components:
Waiver Equipment and Supplies include devices, controls, or appliances specified in the consumer's Person Centered Plan, which enables the client to increase the ability to perform activities of daily living, or to perceive, control or communicate with the environment in which they live. This service also includes durable and non-durable medical equipment not available under the Medicaid State Plan. Items reimbursed with waiver funds shall be in addition to any medical equipment and supplies furnished under the State Medicaid Plan, shall be directly attributable to the client's ability to avoid being institutionalized and shall exclude those items which are not of direct benefit to the client. All items shall meet applicable standards of manufacture, design and installation.

The service includes the following categories of items:
Category 1: Adaptive Positioning Devices – standers, trays and attachments, prone boards and attachments, positioning chairs and sitters, multi-function physiosystem, bolster rolls and wedges, motor activity shapes, therapeutic balls, visualizer ball, physio roll, therapy mats when used in conjunction with adaptive positioning devices.

Category 2: Mobility Aids – walkers, attachments, and accessories not on the regular Medicaid Durable Medical Equipment (DME) list; swivel wheeled scoot-about, adaptive car seats for physically involved clients; free-standing lifts; lift and lift systems for use in the home not on the State DME list; customized/specialized wheelchairs for adults, strollers, accessories and parts not on the State DME list; repair of specialized/customized wheelchairs not on the State DME list; portable telescoping ramps; mobile wheelchair ramps, splints/orthotics for adults (including replacement materials and repairs); prosthetic/orthopedic shoes and devices for adults; protective helmets that are medically necessary for adults.

Category 3: Aids for Daily Living – adaptive eating utensils (cups/mugs; spoons, forks, knives, universal gripping aid for utensils, adjustable universal utensil cuff, utensil

holder, non-skid inner lip plate, sloping, deep plates, scooper, plate guards, non-skid pads
for plate/bowl, wheelchair cup holders); adaptive eating equipment; adaptive, assistive
devices/aids including adaptive switches and attachments; mobile and/or adjustable
tables and trays for chairs, wheelchairs, and beds; adaptive toothbrushes; universal holder
accessories for dressing, grooming, and hygiene; toilet trainer with anterior and lateral
supports; adaptive toileting chairs and bath chairs and accessories not on the State DME
list: adaptive hygiene/dressing aids, adaptive clothing, non-disposable clothing protectors;
reusable incontinence garments with disposable liners for individuals age two and above;
dietary scales, food/fluid thickeners for dysphagia treatment; nutritional supplements that
are taken by mouth such as those supplements covered by Medicaid for Home Infusion
Therapy/Tube feedings; bed rails, assistive listening devices for individuals with hearing
and vision loss (TDD, large visual display devices, Braille screen communicators FM
systems, volume control large print telephones, teletouch systems); medication dispensing
boxes.

Category 4: Augmentative Communication devices are necessary when normal speech is
non-functional and/or when physical impairments make a gestural system impossible
and/or ineffective. An aided system requires access to a symbolic system that is separate
from the body. Selection of devices (and training outcomes for those devices) must be
specific and based on age, cognitive ability, fine and gross motor ability, environmental
need and presence or absence of sensory impairment.

The hardware and software needed to augment communication is divided into the
following categories:

- Low Technology and Clinician-Made Devices
- High Technology, Commercially available Dedicated Devices and

Systems
- Standard Computer/Monitors and Operating peripherals
- Computer Driven devices, Operating peripherals and printers
- Mounting kits and Accessories for each component
- Overlay Kits and accessories
- Switches/Pointers/Access Equipment – all types, Standard and Specialized
- Keyboard/Voice Emulators/Keyguards
- Voice Synthesizers
- Carry Cases
- Supplies (battery, battery charger)
- Artificial Larynges

The cost of the Augmentative Communication Devices shall not exceed $10,000.00 per year.

Category 5: Speech, Cognitive, Perceptual, and Motor Development Treatment/Therapy
Aides – specialized/adapted items necessary to improve visual-perceptual motor skills,
improve integration processing abilities,, improve communication abilities (that are not
covered under the Augmentative Communication service definition), improve gross
motor skills, develop reaching, and/or improve visual attention, focusing, and following.
The cost of Category 5 equipment cannot exceed $200.00 per year.

Provider Requirements:
N/A

Staffing Requirements:
N/A

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:
N/A

Entrance Criteria:
N/A

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
Outcomes must be consistent with the recommendations for the supplies/equipment.

Documentation Requirements:

1. Assessment/recommendation shall be completed by an appropriate professional that identifies the individual's need(s) with regard to the Waiver Equipment and Supplies being requested. Diagnostic information must be consistent with the recommended supplies/equipment. The assessment/ recommendation must state the amount of an item the person needs. The assessment/recommendation must be updated if the amount of the item the person needs changes.
2. A copy of the physician's signature certifying medical necessity shall be included with the request for Waiver Equipment and Supplies. The physician may sign a statement on the assessment/recommendation certifying that the requested supply/equipment is medically necessary or may sign a separate document.

Outcomes/goals related to the person/family's utilization and/or procurement of the requested supplies/equipment must be included in the plan of care. If the equipment/supply is related to outcomes/goals already in the service plan, this should be noted in the request for the equipment/supply.

Service Exclusions:
N/A
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NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Personal Emergency Response Systems (PERS)

Service Definition and Required Components:
PERS is an electronic device which enables certain individuals at high risk of institutionalization to secure help in an emergency. The individual may also wear a portable "help" button to allow for mobility. The system is connected to the person's phone and programmed to signal a response center once a "help" button is activated. The response center is staffed by trained professionals. PERS services are limited to those individuals who live alone, or who are alone for significant parts of the day, who are alone for any period of time and have a written plan for increasing the duration of time spent alone as a means of gaining a greater level of independence, or who have no regular caregiver for extended periods of time, and who would otherwise require extensive routine supervision.

Provider Requirements:
N/A

Staffing Requirements:
N/A

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:
N/A

Entrance Criteria:
The individual is eligible for this service when: The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
N/A

Documentation Requirements:
Maintain a record that documents the date service is started, the dates that it is provided, and the date it was terminated.

Service Exclusions:
N/A

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Consumer/Family Training

Service Definition and Required Components:

Training and counseling services for the covered individual and or family members of the covered individual. Training includes instruction about treatment regimens and use of equipment specified in the Person Centered Plan, and shall include updates as necessary to safely maintain the individual at home. For purposes of this service, "family" is defined as the persons who live with or provide care to a person served on the waiver, and may include a parent, spouse, children, relatives, foster family or in-laws. "Family" does not include individuals who are employed to care for the consumer. All family training must be included in the individual's written Person Centered Plan. Training may also include instructions on how to access services, how to participate in the self-direction of care, how to hire, fire and evaluate service providers, consumer choices and rights, how to manage finances, consumer's personal responsibilities and liabilities when participating in consumer-directed supports (e.g. billing, reviewing and approving timesheets). The service may be billed as a staff service (Professional, para-professional, and group) or may be billed as an invoice to reimburse for training that is delivered in a formal group setting such as a conference registration or enrollment in a community college class.

Provider Requirements:

Consumer/Family Training service must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Consumer/Family Training providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:

Direct Care Staff must have expertise, as appropriate, in the field in which the training is being provided.

Service Type/Setting:

Training may be provided in any setting.

Program Requirements:
N/A

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
Consumer/Family Training is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Maintain progress notes signed by the individual providing the services that meets the requirement in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:
The service is limited to a maximum expenditure of $500.00 per year.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

In-Home Aide Services - Level I

Service Definition and Required Components:
In-Home Aide Services include general household activities, such as meal preparation and routine household care, provided by a trained Level I In-Home Aide, when the individual regularly responsible for these activities is temporarily absent or unable to carry out these activities. In-Home Aide Services at this level provide support to individuals and their families who require assistance with basic home management tasks, such as sweeping and mopping floors, dusting, making an unoccupied bed, cooking, shopping, paying bills, making minor household repairs, ironing and mending clothing.

Note: This is a temporary service and the person and the person's care provider may need referral for other on-going assistance if the care provider is determined to be unable to carry out these activities on an on-going basis.

Provider Requirements:
In-Home Aide services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. In-Home Aide providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements: Service must meet the North Carolina Development Disabilities (NCDD) core competencies. Client specified competencies to be met as identified by the Person Centered Planning Team. Service provider must have a criminal record check, health care registry check, and a medical statement. Must be under the supervision of a qualified professional.

Service Type/Setting:
This service may be provided only in the private residence of the person.

Program Requirements:
N/A

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for In Home Aide.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
In-Home Aide Services is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Maintain service log for each direct service provider that provided services. Service logs must meet the requirements outlined in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:
This service may be provided only in the private residence of the recipient. It may not be provided on the same that the person receive home and community support, residential support. This service may not be provided at the same time of day that the person receive Adult Day Health, Personal Care, Interpreter, Respite, Transportation , o r one the regular Medicaid services that works directly with the person such as PCS, Home Health Services, or individual therapies.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Crisis Stabilization

Service Definition and Required Components:

This support is a more intensive level of intervention service that provides close supervision to the person on an individual basis and assists during periods of time in which the person is presenting episodes of unmanageable and/or inappropriate behaviors, which require specialized staff intervention. An individual may display extreme, maladaptive behaviors that are not anticipated, are temporary in nature, and are beyond the daily behaviors, which are addressed through other supports.

Crisis Stabilization is provided on an hourly basis for periods up to 14 consecutive days per episode. A Ph.D. psychologist or psychiatrist must order the amount and duration of the service with a new order for each episode.

> **Note:** This service may be provided concurrently with the other Waiver services as approved in the individual's Person Centered Plan. This service may be included in the person's initial Person Centered Plan or annual Person Centered Plan update in anticipation that it may be needed, or it may be added during a crisis situation as a Plan Update/Cost Revision. The Case Manager must be notified of any use of Crisis Stabilization Services prior to use of the service if not approved on the Person Centered Plan and on the next working day if the service is already included on the Person Centered Plan. The local Lead Agency should have a provision in their Local Approval Plan for emergency use of Crisis Stabilization Services if this service is to be added in crisis situations.

Provider Requirements:

Crisis Stabilization services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Crisis Stabilization providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:

Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10A NCAC 27A .0204; additional competencies as specified in attachment "Direct Care Staff/Competencies." Client specific competencies to be met as identified by the individual's treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation

Service Type/Setting:
It provides additional one-to-one supervision for the person as needed during an acute crisis situation so that the person can continue to participate in his/her daily routine without interruption. Crisis of this nature may be due to medication changes, reaction to family stress, or other trauma. By providing this service, an imminent institutional admission may be avoided while protecting the person from harming himself/herself or others.

While receiving this service, the person is able to remain in his/her place of residence, in the day program, or in respite care, while a crisis plan is developed and implemented. Crisis Stabilization staff will implement intervention plans as written by a psychologist and/or psychiatrist and which are directed at reducing the maladaptive behavior.

This service is offered in the setting(s) where the person receives services.

Program Requirements:
N/A

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.

C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:

Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Crisis Stabilization.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:

Crisis Stabilization is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:

Maintain documentation of the intervention activities performed by direct service employees through a daily service note. Documentation must meet the requirements outlined in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:

Crisis Stabilization is limited to 14 consecutive days per episode and cannot exceed 2016 hours per fiscal year. It may not be provided during the person's school program, in a hospital setting, a regional MR facility or in an ICF-MR community-based facility. It may not be provided on the same day as Respite Care. This service may not be provided in a regional MR facility or in an ICF-MR community-based facility.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Augmentative Communication Devices

Service Definition and Required Components:
These devices are necessary when normal speech is non-functional and when physical impairments make a gestural system impossible or ineffective. An aided system requires access to a symbolic system that is separate from the body. Selection of devices (and training outcomes for these devices) must be person specific and based on age, cognitive ability, fine and gross motor ability, environmental need and presence or absence of sensory impairment. The hardware and software needed to augment communication is divided into the following categories.

- Low Technology and Clinician-Made Devices
- High Technology, Commercially Available Dedicated Devices and Systems
- Standard Computer/Monitors and Operating Peripherals
- Computer Driven Devices, Operating Peripherals and Printers
- Mounting Kits and Accessories for each component
- Microphones
- Overlay Kits and Accessories
- Cassette Recorders
- Switches/Pointers/Access Equipment - all types, Standard and Specialized
- Keyboard/Voice Emulators/Key guards
- Voice Synthesizers
- Carrying Cases
- Supplies (Battery, Battery Charger)
- Power Strips
- Artificial Larynges

Note: Service and repair of purchased equipment is included when not covered by warranty. Service and repair of rented equipment is included in the rental payment. Repair of equipment may include equipment that was purchased through another funding source if the device would have been covered under the Augmentative Communication definition if purchased as new. This service does cover materials, devices, and aides used to create communication systems other than speech (sign language, picture exchange systems, voice output aides). Also covered are computers and software used for language development including written language development in the absence of functional oral language. Computer ribbons and batteries may be covered only when it can be demonstrated that the life expectancy of those items is consistent with the

reasonable use of those items for use within the definition of augmentative communication. The cost of the printer ribbons and batteries will not be covered when the printer or device requiring batteries is used for purposes other than those stated in the augmentative communication definition.

Limitations: Medicaid does not cover service and maintenance contracts. This service definition does not cover speech therapy materials or fees for Internet access. The total cost of all Augmentative Communication devices cannot exceed $10,000.00 per Waiver year. See Waiver Supplies and Equipment for possible coverage of Speech Therapy materials.

Provider Requirements:
N/A

Staffing Requirements:
N/A

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
N/A

Documentation Requirements:
The Lead Agency maintains documentation of approval prior to ordering the device.

Documentation contained in the Division MH/DD/SAS Service Record Manual (APS-M 45-2 September 03 list the following requirements:

1. Assessment/ recommendation signed and dated by a NC Licensed Speech-Language Pathologist with the SLP's license number shall be submitted with the request. The assessment/recommendation is also signed and dated by other appropriate professionals as needed. The recommendation must be less than one year old from the date the request is received in the Lead Agency Local Approval Office. The assessment confirms medical need for the equipment rather than educational need and identifies the person's need(s) with regard to Augmentative Communication equipment being requested. A copy of the physician's statement certifying medical necessity shall be included with the request.
2. The request shall include clear documentation that the equipment is necessary to enable the individual to produce and engage in communication, either spoken, written, or both, in the absence of functional oral language. Information shall be provided that includes the person's hearing status, visual status, physical status, access for the device requested (i.e. use of hand, visual scanning, auditory scanning, etc.), cognitive status, and primary communication method(s).
3. Outcomes for teaching the use of the device to the consumer and his/her care providers that match the assessment results/device(s) requested shall be included. The estimated life of the equipment, as well as the length of time the person is expected to benefit from the equipment, shall be indicated in the request.
4. An invoice from the supplier that shows the date the Augmentative Communication was provided to the person, and the cost including related charges (for example, applicable delivery charges) shall be maintained by the Lead Agency.

Service Exclusions:

For a child who is enrolled in public schools or is in an age category that requires them to be enrolled in public schools or a home schooling program, the issue of the school's responsibility to fund Augmentative Communication, including items used for language development, should be considered. The child's Individual Education Plan will assist in making the determination of the school's responsibility to provide these items.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Vehicle Adaptations

Service Definition and Required Components:
Vehicle adaptations are devices, controls, or services which enable people to increase their independence or physical safety, and which allow the person to live in their home. The repair, maintenance, installation, and training in the care and use, of these items are included. Vehicle adaptations, repairs, and maintenance of equipment shall be performed by the manufacturer's authorized dealer according to manufacturer's installation instructions, and National Highway and Traffic Safety Administration guidelines. When appropriate, waiver recipients are referred to VR to acquire vehicle adaptations.

The following types of adaptations to the vehicle are allowable:

- Door handle replacements;
- Door height/width alterations;
- Installation of a raised roof or related alterations to existing raised roof systems to improve head clearance;
- Lifting devices;
- Devices for securing wheelchairs or scooters;
- Devices for transporting wheelchairs or scooters;
- Adapted steering, acceleration, signaling, and braking devices only when recommended by a physician and a certified driving evaluator for people with disabilities, and when training installed device is provided by certified personnel;
- Handrails and grab bars; and
- Lowering of the floor of the vehicle.

The cost effectiveness of the vehicle adaptations, relative to alternative transportation services, must be considered. Adaptations to vehicles are limited to vehicles owned by the person 's family and are limited to one vehicle. For purposes of this service, "family" is defined as the persons who live with or provide care to a recipient of Waiver services, and may include a biological parent, adoptive parent, step parent, foster family member, child, spouse, in-law, other relative, or domestic partner (in those jurisdictions in which domestic partners are legally recognized). "Family" does not include individuals who are employed to care for the person. Vehicle adaptations are only provided as a waiver service when they are documented in the individual's Person Centered Plan, required documentation is supplied, and the adaptation is necessary to avoid institutionalization.

Recipients are referred to VR when appropriate. They have staff who have expertise in assessing the needs of the person and making specific recommendations for the type of modification to meet the needs of the person with the vehicle. In the event that VR services are determined not to be an appropriate resource, the following process is utilized.

- All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications. Both VR and dealers have staff to provide this type of assessment.
- All equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to insure the most efficient use of Medicaid funds.
- The recommended equipment or modification will be justified by an assessment from a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation Specialist and accompanied by a physician's signature certifying medical necessity for the person. These assessments shall contain information regarding the rationale for selected modification, recipient pre-driving assessment if the CAP-MR/DD recipient will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.
- Documentation regarding each of the requirements specified above, as well as a revised Cost Summary and POC Signature Page must be submitted to the Lead Agency Local Approver in order to obtain prior approval of the requested Vehicle Adaptations.

Note: The modification must meet applicable standards and safety codes. Case Managers should inspect the completed adaptation from a health and safety perspective. The training plan for use of the modification shall be included in the individual's Person Centered Plan. The responsibility of the family keeping their insurance current is between the Department of Motor Vehicles and the family. Waiver funding will not be approved, however, to replace a lift if the family fails to keep their insurance current and needs payment for repairs of the equipment that would have been expected to be covered by insurance.

Provider Requirements:

N/A

Staffing Requirements:
N/A

Service Type/Setting:
N/A

Program Requirements:
N/A

Utilization Management:
N/A

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
N/A

Discharge Criteria:
N/A

Expected Outcomes:
N/A

Documentation Requirements:
Recipients are referred to VR when appropriate. They have staff who have expertise in assessing the needs of the person and making specific recommendations for the type of modification to meet the needs of the person with the vehicle. In the event that VR services are determined not to be an appropriate resource, the following process is utilized.

- All vehicles must be evaluated by an adapted vehicle supplier with an emphasis on safety and "life expectancy" of the vehicle in relationship to the modifications. Both VR and dealers have staff to provide this type of assessment.
- All equipment purchased through CAP-MR/DD funds will utilize a bid or competitive invoice process to insure the most efficient use of Medicaid funds.
- The recommended equipment or modification will be justified by an assessment from a Physical Therapist/Occupational Therapist specializing in vehicle modifications or a Rehabilitation Engineer or Vehicle Adaptation Specialist and accompanied by a physician's signature certifying medical

necessity for the person. These assessments shall contain information regarding the rationale for selected modification, recipient pre-driving assessment if the CAP-MR/DD recipient will be driving the vehicle, condition of the vehicle to be modified, insurance on the vehicle to be modified, and training plan for the use of the prescribed modification.

- Documentation regarding each of the requirements specified above, as well as a revised Cost Summary and POC Signature Page must be submitted to the Lead Agency Local Approver in order to obtain prior approval of the requested Vehicle Adaptations.

Service Exclusions:
Vehicle modifications do not cover the cost of the vehicle to be modified or the cost of rental of vehicles with adaptations on them. A family may choose to purchase a vehicle (new or used) that already has modifications on it. In such cases the process for approval of the adaptation remains the same. The price of the used lift on the used vehicle must be assessed and the current value (not the replacement value) may be approved under this service definition to cover this part of the purchase price. In such instances, the person/family may not take possession of the lift prior to being approved via the Lead Agency Approval Process.

Note: If paying for labor and costs of moving devices/equipment from one vehicle to another vehicle, then training on the use of the device is not required.

Limitation: The total cost of all vehicle adaptations provided in one year cannot exceed $10,000.00.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Interpreter Services

Service Definition and Required Components:
Interpreter Services is a service designed to provide effective, accurate, and impartial receptive and expressive interpreter and/or transliterating services for a waiver recipient who is deaf, hard of hearing, or deaf and blind, using any specialized vocabulary needed by that recipient. Interpreting is specific to the recipient's disability and denotes a skill in communication between sign language and spoken language. Transliterating denotes a skill in communication between spoken English and English-like signing or non-audible spoken English. Tactile interpreting or close vision services are also provided under this service.

> **Note:** Only direct service to the recipient may be billed.
> **Limitation:** The total reimbursement time under the Waiver cannot exceed 24 hours per Waiver year.

Provider Requirements:
Interpreter services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Interpreter Service providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:
English Provider must competent in transliterating in communication between spoken and English-like signing or non-audible spoke English.

Service Type/Setting:
Interpreter Service maybe provided in any location.

Program Requirements:
N/A

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Interpreter services.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Interpreter services is directed toward the habilitation of recipients with developmental disabilities in the areas of receptive and expressive language, and learning.

Documentation Requirements:
Maintain service documentation signed by and dated by interpreter providing the service which meets the requirement of a full service note in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:
Travel time, preparation time, and documentation time are not billable.
This service may not be provided at the same time of day that a person receives:

Adult Day Health	Day Habilitation
Developmental Day Care	In-Home Aide
MR Personal Care	Respite Care
Supported Employment	Supported Living
Transportation	

or

One of the regular Medicaid services that works directly with the person, such as PCS, Home Health Services, MH/DD/SAS Community Services , or individual therapies.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Therapeutic Case Consultation

Service Definition and Required Components:
Therapeutic Case Consultation provides the provision of expertise, training and technical assistance in a specialty area (psychology, behavioral analysis, therapeutic recreation, speech therapy, occupational therapy, physical therapy, or nutrition) to assist family members, caregivers, and other direct service employees in supporting individuals with developmental disabilities who have long term habilitative treatment needs. Under this model, family members and other paid/unpaid caregivers are trained by a licensed professional to carry out therapeutic interventions, which will provide consistency, therefore increasing the effectiveness of the specialized therapy. This service will also be utilized to allow specialists as defined to be an integral part of the treatment team by participating in team meetings and providing additional intensive consultation and support for individuals whose medical and/or behavioral/psychiatric needs are considered to be extreme or complex.

The activities addressed below are not covered under the State Plan but are covered under the Therapeutic Case Consultation definition.

Activities:
The activities outlined below take place with and without the person being present. These activities will be observed and assessed on at least a quarterly basis.

1. Observing the individual prior to the development/revision of the Support Plan to assess and determine treatment needs and the effectiveness of current interventions/support techniques.
2. Constructing a written Support Plan to clearly delineate the interventions and activities to be carried out by family members, caregivers and program staff. The Support Plan details strategies, responsibilities, and expected outcomes.
3. Training relevant persons to implement the specific interventions/supports techniques delineated in the Support Plan and to observe the person, to record data, and to monitor implementation of therapeutic interventions/support strategies.
4. Reviewing documentation and evaluating the activities conducted by family members, caregivers, or program staff as delineated in Support Plan with revision of that Plan as needed to assure continued relevance and

progress toward achievement of outcomes.

Note: This does not cover activities billable under the Case Management Service definition.

5. Training and technical assistance to family members, caregivers, and other
individuals primarily responsible for carrying out the person's Person Centered Plan on the specific interventions/activities, delineated in Support Plan, outcomes expected and review procedures.

6. Participating in treatment team meetings.

Criteria

The need for Therapeutic Case Consultation must be clearly reflected on the individual's Person Centered Plan. Therapeutic Case Consultation may not include direct therapy provided to Waiver recipients, nor duplicate the activities of other services that are available to the individual through the Medicaid State Plan.

Note: This service is based on the needs of the individual as identified by the treatment team and indicated on the Person Centered Plan. Travel time, written preparation, and telephone communications are not billable as separate items. Therapists and paid para-professional caregivers are able to bill for their service concurrently. Training provided by the therapist to the QP is included in the habilitative service rate.

Provider Requirements:

Therapeutic Case Consultation services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Therapeutic Case Consultation providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:

Service provider must hold appropriate NC license for PT, OT, ST, psychology, nutrition, national certification for Recreation Therapy.

Service Type/Setting:
This service is provided in the recipient's home.

Program Requirements:
N/A

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Therapeutic Case Consultation .
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Therapeutic Case Consultation is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Maintain a full service note signed and dated by the direct care employee providing the service. The service note must meet the requirements out in the Division MH/DD/SAS Service Record Manual.

Service Exclusions:
Limitation: The total cost reimbursable under the Waiver will not exceed $1,500.00 per Waiver year. Time travel, written preparation, and telephone communication are not billable as separate items. Training provided by the therapist to the qualified professional is included in the habilitative service rate.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Home Community Support

Service Definition and Required Components:

Home and Community Supports (HCS) Assistance to individuals for acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community-based settings. Habilitation, training and instruction are coupled with elements of support, supervision and engaging consumer participation to reflect the natural flow of training, practice of skills, and other activities as they occur during the course of the consumer's day. *(This service is distinctive in that it includes active treatment, habilitation and training activities. Interactions with the consumer are designed to achieve outcomes identified in the individual Person Centered Plan. Support and supervision of consumer activities to sustain skills gained through habilitation and training is also an acceptable goal of HCS.)*

Provider Requirements:

This is not provider requirements Home and Community Supports (HCS) services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Home and Community Supports (HCS) providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:

Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10A NCAC 27G .0204; additional

competencies as specified in attachment "Direct Care Staff/Competencies." Client specific competencies to be met as identified by the individual's treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation

Service Type/Setting:
This service may be provided in the home or community and is designed to go with the consumer and assist in a variety of settings.

Program Requirements:
Home Community Support services shall focus on enabling the individual to attain or maintain his or her maximum functional level and shall be coordinated with any physical, occupational, or speech therapies listed in the Person Centered Plan. In addition, day habilitation services may serve to reinforce skills or lessons taught in school, therapy, or other settings.

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Home Community Support .
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Home Community Support service is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Maintain a service record format utilizing the service grid outlined in the Division MH/DD/SAS (APS-M 45-2 September 03). This shall be completed daily to reflect service provided.`

Service Exclusions:
Home and Community Support cannot be provided on the at the same day as Residential Supports, In-Home Aide, Personal Care. Home and Community Support cannot be provided the same time as Adult Day Health, Respite, Transportation, Interpreter, and Supported Employment.

NORTH CAROLINA DIVISION OF MH/DD/SAS
SERVICE STANDARDS

Residential Support

Service Definition and Required Components:

Residential Supports can only be provided in licensed residential settings of eight (8) beds or less and/or Alternative Family Living Settings not subject to licensure (example: only one adult consumer living in the home.) Payments for residential habilitation are not made for room and board, the cost of facility maintenance, upkeep and improvement, other than such costs for modifications or adaptations to a facility required to assure the health and safety of residents, or to meet the requirements of the applicable life safety code. Payment for residential habilitation does not include payments made, directly or indirectly, to members of the individual's immediate family. Payments will not be made for the routine care and supervision which would be expected to be provided by a family or group home provider, or for activities or supervision for which a payment is made by a source other than Medicaid.

Provider Requirements:

Residential Supports services must be delivered by a developmental disabilities provider organization which meets standards established by the Division of MH/DD/SAS. These standards set forth the administrative, financial, clinical, quality improvement, and information services infrastructure necessary to provide services. Providers must demonstrate that they meet these standards by either being certified by the local Management Entity or being accredited by a national accrediting body. The organization must be established as a legally recognized entity in the United States and qualified/registered to do business in the State of North Carolina. Generally, only one service that directly involves the person is provided at a time. Residential Supports providers may be members of the individual's family. Standards for family members providing personal care services differ from those for other providers of this service.

Staffing Requirements:

Worker Qualifications: must meet requirements for paraprofessional in 10A NCAC 27G .0204; personnel requirements in 10A NCAC 27G .0202; competencies and supervision requirements in 10A NCAC 27G .0204; additional competencies as specified in attachment “Direct Care Staff/Competencies.” Client specific competencies to be met as identified by the individual’s treatment team and documented in the plan of care. Direct care staff must have a criminal record check and healthcare registry check. Driving record must be checked if providing transportation

Service Type/Setting:

Residential Support must be provided in a licensed residential settings of eight (8) beds or less and/or Alternative Family Living Settings not subject to licensure.

Program Requirements:
This service is distinctive in that it includes active treatment, habilitation and training activities. Interactions with the consumer are designed to achieve outcomes identified in the individual plan of care.

Utilization Management:
Referral and service authorization is the responsibility of the Lead Management Entity. Utilization review must be conducted every XXX days and is so documented in the person centered plan and service record.

Entrance Criteria:
The individual is eligible for this service when:
The person meets the eligibility for the CAP- MR Waiver program

Continued Stay Criteria:
The desired outcome or level of functioning has not been restored, improved, or sustained over the time frame outlined in the recipient's person centered plan or the recipient's continues to be at risk for regression based on history or tenuous nature of the functional gains or anyone of the following apply:

A. Recipient has achieved initial service plan goals and additional goals are indicated.
B. Recipient is making satisfactory progress toward meeting goals.
C. Recipient is making some progress, but the service plan (specific interventions) need to be modified so that greater gains can be achieved.
D. Recipient is not making progress; the service plan must be modified to identify more effective interventions.

Recipient is regressing; the service plan must be modified to identify more effective interventions

Discharge Criteria:
Recipient's level of functioning has improved with respect to the goals outlines in the service plan, inclusive of a transition plan to step down, or no longer benefits, or has the ability to function at this level of acre and any of the following apply:

1. Recipient has achieved goals and is no longer eligible for Residential Support.
2. Recipient is not making progress, or is regressing and all realistic treatment options have been exhausted.
3. Recipient/family no longer wants service.

Note: Any denial, reduction, suspension or termination of service requires notification to the recipient and/or legal guardian about their appeal rights.

Expected Outcomes:
Residential Support is directed toward the habilitation of recipients with developmental disabilities in the areas of self care, receptive and expressive language, learning, mobility, self-direction, capacity for independent living or economic self-sufficiency.

Documentation Requirements:
Maintain a service record format utilizing the service grid outlined in the Division MH/DD/SAS (APS-M 45-2 September 03). This shall be completed daily to reflect service provided.`

Service Exclusions:
Residential Support cannot be provided on the at the same day as Home and Community Supports, In-Home Aide, Personal Care. Residential Support cannot be provided the same time as Adult Day Health, Respite, Transportation, Interpreter, and Supported Employment.